Psychiatric Care of the Older Adult

An Overview for Primary Care

Shaune DeMers, MD*, Kyl Dinsio, MD, Whitney Carlson, MD

KEYWORDS

• Geriatric patients • Primary care • Delirium • Dementia • Depression
• Substance abuse • Alcohol misuse • Caregivers

KEY POINTS

- Suspect delirium in any acute mental status change. Polypharmacy, medications, metabolic derangements, and infections are common causes for delirium.
- Dementia is a common and increasingly frequent diagnosis made in primary care settings. A structured approach combining history from patients, a collateral source, and bedside cognitive testing will usually establish a diagnosis.
- Depression is a common comorbidity that has negative impacts on health status and quality of life. Depression treatment should be tailored to the individual patient and treatment continued until remission is achieved.
- Although alcohol and substance misuse is less common among older adults, the prevalence is increasing. Older patients with changes in mood or cognition should be screened for alcohol and drug problems, particularly prescription medication overuse.
- Caregivers for older patients are usually a spouse or adult children and suffer significant morbidity. The primary care provider is often in the best position to assist caregivers with their own stress and to provide direction for more assistance.

INTRODUCTION: APPROACH TO OLDER ADULT PATIENTS

Primary care providers (PCPs) in the United States will be devoting increasing time to the management of geriatric patients. Between 2012 and 2050, the number of persons older than 65 years is expected to increase dramatically, from 43.1 million to 88.5 million.[1] This increase is a motivator for recent calls for an expansion of the primary care workforce by 52,000 physicians, with recognition that the numbers of geriatric specialists will not be sufficient to meet the demand.[2] In fact, the number of geriatric

The authors have no conflicts of interest to disclose.
Division of Geriatric Psychiatry, Harborview Medical Center and University of Washington, Box 359760, 325 Ninth Avenue, Seattle, WA 98104-2499, USA
* Corresponding author.
E-mail address: sdemers@uw.edu

Med Clin N Am 98 (2014) 1145–1168
http://dx.doi.org/10.1016/j.mcna.2014.06.010 **medical.theclinics.com**
0025-7125/14/$ – see front matter

internists and psychiatrists is expected to remain stable or even decline in the next decades.[3]

Older adults are in many ways similar to their younger counterparts, but important differences are highlighted in this overview as we consider the case of Mr Q (**Box 1**). Differential diagnoses for his presentation will allow us to review the most common psychiatric problems encountered in the primary care setting (delirium, dementia, depression, and substance misuse) and to discuss another critical issue, caregiver health and well-being.

DELIRIUM

Mr Q could be suffering from delirium. Most delirious patients are located in hospitalized or intensive care unit (ICU) settings, making it less common in primary care offices. However, although the base rate for delirium in outpatient settings is low (1%–2%), it increases dramatically with increasing age, increasing to 14% among individuals older than 85 years living in the community.[4,5] Primary care doctors are additionally likely to encounter an acute delirium in nursing home or end-of-life patients where prevalence increases to 60% and more than 80%, respectively.[5]

Delirium is an acute confusional state, characterized by deficits in attention, level of consciousness, orientation, memory, language, and ability to communicate and visual hallucinations or paranoia (**Box 2**). It is an abrupt change in mental status that is always driven by an underlying medical cause. The Confusion Assessment Method is an easy-to-use screening tool that has been validated for the detection of delirium.[6,7] The evolution of a delirium arises from some underlying vulnerability in patients combined with an acute medical insult or medication effect (**Box 3**). Older patients with dementia are particularly at risk for the development of a delirium, and the clinical picture of a delirium superimposed on top of dementia is quite common.[8] In elderly patients, even relatively minor medical disturbances, such as a urinary tract infection, mild dehydration, or even constipation, can cause a delirium. Other common causes are medications (particularly polypharmacy or postanesthesia), infections, and cardiac or cerebrovascular events.

Delirium is differentiated from dementia in that its onset is an *acute* change from the person's baseline. The time course of development of a delirium is hours to days, whereas in dementia it is months to years. The presence of a delirium necessitates an investigation into the underlying medical problems that are causing the change in mental status; often there are multiple contributing causes. In all cases, the

Box 1
The case of Mr Q

Mr Q is a 75-year-old retired anthropology professor with no psychiatric history whom you have been following for many years for the management of type II diabetes, hypertension, and occasional falls. He comes to the clinic for a 6-month check-up with his wife of 42 years and for the first time seems confused about his medications.

Questions

1. Is he delirious?
2. Has he developed cognitive impairment?
3. Could he be depressed?
4. What about alcohol or other drug intoxication or withdrawal?
5. How is his wife doing?